DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/24/2015 FORM APPROVED OMB NO. 0938-0391

	F DEFICIENCIES CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING A. BUILDING		(X3) DATE SURVEY COMPLETED		
		155349	B. WING _		R 02/12/2015
NAME OF PROVIDER OR SUPPLIER SAINT ANNE HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 1900 RANDALLIA DR FORT WAYNE, IN 46805	1 02/12/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CORREC ((EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLETION
{F 000}	INITIAL COMMENTS Paper compliance to	the recertification and state	{F 0	00}	
	licensure survey com Review date: Februa	oleted on January 13, 2015. ry 12, 2015.			
	Provider number: 1	00240 55349 00274960			
	Surveyor: Randall Fr	y RN			
	410 IAC 16.2 in regar	k was found to be in FR Part 483, subpart B and d to the paper compliance cation and state license			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.